

Patient's Name: \_\_\_\_\_  
(Last) (First) (M.I.)

**REPORT OF VERIFIED CASE  
OF TUBERCULOSIS**

Street Address: \_\_\_\_\_  
(Number, Street, City, State)

Zip Code: \_\_\_\_\_



**REPORT OF VERIFIED CASE OF TUBERCULOSIS**

DEPARTMENT OF HEALTH & HUMAN SERVICES  
PUBLIC HEALTH SERVICE  
CENTERS FOR DISEASE CONTROL  
AND PREVENTION (CDC)  
ATLANTA, GEORGIA 30333

FORM APPROVED OMB NO. 0920-0026 Exp. Date 09/30/2005

**SOUNDEX**

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**1. State Reporting:**

Specify: \_\_\_\_\_

Alpha State Code 

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**2. State Case Number:**

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**City/County Case Number:**

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**3. Date Submitted:**

By: \_\_\_\_\_

Mo.	Day	Yr.						
<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>		

**5. Month-Year Reported:**

Mo.	Yr.				
<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>		

**6. Month-Year Counted:**

Mo.	Yr.				
<table border="1"><tr><td> </td><td> </td></tr></table>			<table border="1"><tr><td> </td><td> </td></tr></table>		

**7. Date of Birth:**

Mo.	Day	Yr.						
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**8. Sex:**

- 1 ☐ Male  
2 ☐ Female

**9. Ethnicity:**  
(Select one)

- 1 ☐ Hispanic or Latino  
2 ☐ Not Hispanic or Latino

**10. Race:**  
(Select one or more)

- 1 ☐ American Indian or Alaska Native  
2 ☐ Asian Specify (Optional): \_\_\_\_\_  
3 ☐ Black or African American  
4 ☐ Native Hawaiian or Other Pacific Islander Specify (Optional): \_\_\_\_\_  
5 ☐ White

**11. Country of Origin:**

If U.S., check here ☐ If not U.S., enter country code (see list) 

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**4. Address for Case Counting:**

City 

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Within City Limits 1 ☐ Yes 2 ☐ No

County 

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Zip Code 

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**14. Previous Diagnosis of Tuberculosis:**

- 1 ☐ Yes  
2 ☐ No

Yr. 

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 If yes, list year of previous diagnosis

- 1 ☐ If more than one previous episode, check here

**15. Major Site of Disease:**

- 00 ☐ Pulmonary  
10 ☐ Pleural  
21 ☐ Lymphatic: Cervical  
22 ☐ Lymphatic: Intrathoracic  
23 ☐ Lymphatic: Other  
29 ☐ Lymphatic: Unknown  
30 ☐ Bone and/or Joint  
40 ☐ Genitourinary  
50 ☐ Miliary  
60 ☐ Meningeal  
70 ☐ Peritoneal  
80 ☐ Other\*  
90 ☐ Site not Stated

\*If site is "Other", enter anatomic code (see list) 

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**16. Additional Site of Disease:**

- 00 ☐ Pulmonary  
10 ☐ Pleural  
21 ☐ Lymphatic: Cervical  
22 ☐ Lymphatic: Intrathoracic  
23 ☐ Lymphatic: Other  
29 ☐ Lymphatic: Unknown  
30 ☐ Bone and/or Joint  
40 ☐ Genitourinary  
50 ☐ Miliary  
60 ☐ Meningeal  
70 ☐ Peritoneal  
80 ☐ Other\*  
90 ☐ Site not Stated

\*If site is "Other", enter anatomic code (see list) 

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If more than one additional site, check here 

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**17. Sputum Smear:**

- 1 ☐ Positive  
2 ☐ Negative  
3 ☐ Not Done  
9 ☐ Unknown

**18. Sputum Culture:**

- 1 ☐ Positive  
2 ☐ Negative  
3 ☐ Not Done  
9 ☐ Unknown

**19. Microscopic Exam of Tissue and Other Body Fluids:**

- 1 ☐ Positive  
2 ☐ Negative  
3 ☐ Not Done  
9 ☐ Unknown

If positive, enter anatomic code(s) (see list) 

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**20. Culture of Tissue and Other Body Fluids:**

- 1 ☐ Positive  
2 ☐ Negative  
3 ☐ Not Done  
9 ☐ Unknown

If positive, enter anatomic code(s) (see list) 

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**22. Tuberculin (Mantoux) Skin Test at Diagnosis:**

- 1 ☐ Positive  
2 ☐ Negative  
3 ☐ Not Done  
9 ☐ Unknown

Millimeters (mm) of Induration 

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If Negative, was patient anergic? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**21. Chest X-Ray:**

- 1 ☐ Normal  
2 ☐ Abnormal  
3 ☐ Not Done  
9 ☐ Unknown

If Abnormal (check one) 1 ☐ Cavitory

2 ☐ Noncavitory Consistent with TB

3 ☐ Noncavitory Not Consistent with TB

If Abnormal (check one) 1 ☐ Stable

3 ☐ Improving

2 ☐ Worsening 9 ☐ Unknown

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

## REPORT OF VERIFIED CASE OF TUBERCULOSIS

**23. HIV Status:** 0 ☐ Negative 3 ☐ Refused 9 ☐ Unknown  
1 ☐ Positive 4 ☐ Not Offered  
2 ☐ Indeterminate 5 ☐ Test Done, Results Unknown

**24. Homeless Within Past Year:**

0 ☐ No  
1 ☐ Yes  
9 ☐ Unknown

**If Positive, Based on:** 1 ☐ Medical Documentation 2 ☐ Patient History 9 ☐ Unknown

**If Positive, List:** CDC AIDS Patient Number  (If AIDS Reported before 1993)

State HIV/AIDS Patient Number  (If AIDS Reported 1993 or Later)

City/County HIV/AIDS Patient Number  (If AIDS Reported 1993 or Later)

**25. Resident of Correctional Facility at Time of Diagnosis:** 0 ☐ No 1 ☐ Yes 9 ☐ Unknown

If Yes, 1 ☐ Federal Prison 3 ☐ Local Jail 5 ☐ Other Correctional Facility  
2 ☐ State Prison 4 ☐ Juvenile Correctional Facility 9 ☐ Unknown

**26. Resident of Long-Term Care Facility at Time of Diagnosis:** 0 ☐ No 1 ☐ Yes 9 ☐ Unknown

If Yes, 1 ☐ Nursing Home 4 ☐ Mental Health Residential Facility 6 ☐ Other Long-Term Care Facility  
2 ☐ Hospital-Based Facility 5 ☐ Alcohol or Drug Treatment Facility 9 ☐ Unknown  
3 ☐ Residential Facility

**27. Initial Drug Regimen:**

	NO	YES	UNK.
Isoniazid	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Rifampin	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Pyrazinamide	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Ethambutol	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Streptomycin	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

	NO	YES	UNK.
Ethionamide	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Kanamycin	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Cycloserine	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Capreomycin	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Para-Amino Salicylic Acid	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

	NO	YES	UNK.
Amikacin	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Rifabutine	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Ciprofloxacin	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Ofloxacin	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>
Other	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/>

**28. Date Therapy Started:**

Mo.	Day	Yr.
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

**29. Injecting Drug Use Within Past Year:**

0 ☐ No 1 ☐ Yes 9 ☐ Unknown

**30. Non-Injecting Drug Use Within Past Year:**

0 ☐ No 1 ☐ Yes 9 ☐ Unknown

**31. Excess Alcohol Use Within Past Year:**

0 ☐ No 1 ☐ Yes 9 ☐ Unknown

**32. Occupation** (Check all that apply within the past 24 months):

1 <input type="checkbox"/> Health Care Worker	3 <input type="checkbox"/> Migratory Agricultural Worker	5 <input type="checkbox"/> Not Employed within Past 24 Months
2 <input type="checkbox"/> Correctional Employee	4 <input type="checkbox"/> Other Occupation	9 <input type="checkbox"/> Unknown

**Comments:**

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1st Copy

2nd Copy

3rd Copy

**PRINTER NOTE**  
**PLEASE STRIP-IN ABOVE COPY NAMES ON**  
**CENTER BOTTOM OF REQUIRED COPY PAGE**